(G) Average Private Pay Rate. The usual and customary charge for private patient determined by dividing total private patient days of care into private patient revenue net of contractual allowances and bad debt expense for the same service that is included in the Medicaid reimbursement rate. This excludes negotiated payment methodologies with State or Federal agencies such as the Veteran's Administration or the Missouri Department of Mental Health.

(H) Capital. This cost component will be calculated using a Fair Rental Value System. The fair rental value is reimbursed in lieu of the costs reported on lines 102-109 of the cost report version MSIR-1 (3-95) except for amortization of organizational costs.

(I) Capital Asset. A facility's building, building equipment, major moveable equipment, minor equipment, land, land improvements, and leasehold improvements as defined in HIM-15. Motor vehicles are excluded from this definition.

(J) Capital Asset Debt. The debt related to the capital assets as determined from the desk audited and/or field audited cost report.

(K) Ceiling. The ceiling is determined by applying a percentage to the median per diem for the patient care, ancillary and administration cost components. The percentage is 120% for patient care, 120% for ancillary and 110% for administration.

(L) Certified Bed. Any HIV nursing facility bed that is certified by the Division of Aging to participate in the Medicaid Program.

(M) Change of Ownership. A change in ownership, control, operator or leasehold interest, for any facility certified for participation in the Medicaid Program.

(N) Cost Components. The groupings of allowable costs used to calculate a facility's per diem rate. They are patient care, ancillary, capital and administration. In addition, a working capital allowance is provided.

(O) Cost Report. The Financial and Statistical Report for Nursing Facilities, required attachments as specified in paragraph (10)(A)8. of this regulation and all worksheets supplied by the Division for this purpose. The cost report shall detail the cost of rendering both covered and non-covered services for the fiscal reporting period in accordance with this regulation, cost report instruction and on forms or diskettes provided by or as approved by the Division or both.

(P) Databank. The data from the desk audited and/or field audited rate setting cost report for HIV nursing facilities.

(Q) Department. The Department, unless otherwise specified, refers to the Missouri Department of Social Services.

(R) Desk Audit. The Division of Medical Services' or its authorized agent's audit of a provider's cost report without a field audit.

(S) Director. The Director, unless otherwise specified, refers to the Director, Missouri Department of Social Services.

(T) Division of Aging. The Division of the Department of Social Services responsible for survey, certification and licensure as prescribed in Chapter 198 RSMo.

(U) Division. Unless otherwise specified, Division refers to the Division of Medical Services, the Division of the Department of Social Services charged with administration of Missouri's Medical Assistance (Medicaid) Program.

(V) Entity. Any natural person, corporation, business, partnership or any other fiduciary unit.

(W) Facility Asset Value. Total asset value less adjustment for age of beds.

(X) Facility Fiscal Year. A facility's twelve (12) month fiscal reporting period covering the same twelve (12) month period as its federal tax year.

(Y) Facility Size. The number of licensed HIV nursing facility beds as determined from the desk audited and/or field audited cost report.

(Z) Fair Rental Value System. The methodology used to calculate the reimbursement of capital.

(AA) Field Audit. An on-site audit of the HIV nursing facility's records performed by the Department or its authorized agent.

(BB) Generally Accepted Accounting Principles (GAAP). Accounting conventions, practices, methods, rules and procedures necessary to describe accepted accounting practice at a particular time as established by the authoritative body establishing such principles.

(CC) HCFA Market Basket Index. An index showing nursing home market basket indexes. The index is published quarterly by DRI/McGraw Hill. The table used in this regulation is titled "DRI Health Care Cost - National Forecasts, HFCA Nursing Home without Capital Market Basket."

(DD) HIV Nursing Facility. Any facility licensed under Chapter 198 RSMo granted a Certificate of Need under 197.319 RSMo (1994) and certified by the Division of Aging.

(EE) HIV Nursing Facility Resident. A person that resides in a HIV Nursing Facility that has the HIV that causes AIDS.

(FF) Interim Rate. The interim rate shall be based upon the budgeted cost report ((version MSIR-1 (3-95)) that has been submitted to the Division. The interim rate shall be the sum of 100% of the budgeted patient care costs, 90% of the budgeted ancillary costs and administration costs, 95% of the capital cost, and the working capital allowance using the interim rate cost components.

(GG) Licensed Bed. Any Skilled Nursing Facility or Intermediate Care Facility bed meeting the licensing requirement of the Division of Aging.

(HH) Median. The middle value in a distribution, above and below which lie an equal number of values. This distribution is based on the databank.

(II) Nursing Facility (NF). Effective October 1, 1990, Skilled Nursing Facilities, Skilled Nursing Facilities/Intermediate Care Facilities and Intermediate Care Facilities as defined in Chapter 198 RSMo participating in the Medicaid Program will all be subject to the minimum Federal requirements found in section 1919 of the Social Security Act.

(JJ) Occupancy Rate. A facility's total actual patient days divided by the total bed days for the same period as determined from the desk audited and/or field audited cost report. For a distinct part facility that completes a worksheet one (1) of cost report, version MSIR-1 (3-95), determine the occupancy rate from the total actual patient days from the certified portion of the facility divided by the total bed days from the certified portion for the same period, as determined from the desk audited and/or field audited cost report.

(KK) Patient Care. This cost component includes the following lines from the cost report version MSIR-1 (3-95): lines 46-69.

(LL) Patient Day. The period of service rendered to a patient between the census-taking hour on two (2) consecutive days. Census shall be taken in all facilities at midnight each day and a census log maintained in each facility for documentation purposes. "Patient day" includes the allowable temporary leave-of-absence days per subsection (5)(D) and hospital leave days per subsection (5)(M). The day of discharge is not a patient day for reimbursement unless it is also the day of admission.

(MM) Per Diem. The daily rate calculated using this regulation's cost components and used in the determination of a facility's prospective and/or interim rate.

(NN) Provider or Facility. A HIV nursing facility with a valid Medicaid participation agreement with the Department of Social Services for the purpose of providing HIV nursing facility services to Title XIX eligible recipients.

(OO) Prospective Rate. The rate determined from the rate setting cost report.

(PP) Rate Setting Cost Report. The second full twelve (12) month fiscal year desk audited and/or field audited cost report.

(QQ) Rate Setting Period. The full twelve (12) month period in which a facility's prospective rate is determined.

(RR) Reimbursement Rate. A prospective or interim rate.

(SS) Related Parties. Parties are related when any one (1) of the following circumstances apply:

1. An entity where, through its activities, one (1) entity's transactions are for the benefit of the other and such benefits exceed those which are usual and customary in such dealings.

2. An entity has an ownership or controlling interest in another entity; and the entity, or one (1) or more relatives of the entity, has an ownership or controlling interest in the other entity. For the purposes of this paragraph, ownership or controlling interest does not include a bank, savings bank, trust company, building and loan association, savings and loan association, credit union, industrial loan and thrift company, investment banking firm or insurance company unless the entity directly, or through a subsidiary, operates a facility.

3. As used in this regulation, the following terms mean:

A. Indirect ownership/interest means an ownership interest in an entity that has an ownership interest in another entity. This term includes an ownership interest in any entity that has an indirect ownership interest in an entity;

B. Ownership interest means the possession of equity in the capital, in the stock, or in the profits of an entity. Ownership or controlling interest is when an entity:

(I) Has an ownership interest totaling five percent (5%) or more in an entity;

(II) Has an indirect ownership interest equal to five percent (5%) or more in an entity. The amount of indirect ownership interest is determined by multiplying the percentages of ownership in each entity;

(III) Has a combination of direct and indirect ownership interest equal to five percent (5%) or more in an entity;

(IV) Owns an interest of five percent (5%) or more in any mortgage, deed of trust, note, or other obligation secured by an entity if that interest equals at least five percent (5%) of the value of the property or assets of the entity. The percentage of ownership resulting from these obligations is determined by multiplying the percentage of interest owned in the obligation by the percentage of the entity's assets used to secure the obligation;

(V) Is an officer or director of an entity; or

(VI) Is a partner in an entity that is organized as a partnership.

C. Relative means person related by blood, adoption or marriage to the fourth degree of consanguinity.

(TT) Replacement Beds. Newly constructed beds never certified for Medicaid or previously licensed by the Division of Aging or the Department of Health and put in service in place of existing Medicaid beds. The number of replacement beds being certified for Medicaid shall not exceed the number of beds being replaced.

(UU) Renovations/Major Improvements. Capital cost incurred for improving a facility excluding replacement beds and additional beds.

(VV) Restricted Funds. Funds, cash, cash equivalents or marketable securities, including grants, gifts, taxes and income from endowments which must only be used for a specific purpose designated by the donor.

(WW) Total Facility Size. Facility size plus increases minus decreases of licensed HIV nursing facility beds plus calculated bed equivalents for renovations/major improvements.

(XX) Unrestricted Funds. Funds, cash, cash equivalents or marketable securities, including grants, gifts, taxes and income from endowments, that are given to a provider without restriction by the donor as to their use.

(5) Covered Supplies, Items and Services. All supplies, items and services covered in the reimbursement rate must be provided to the resident as necessary. Supplies and services which would otherwise be covered in a reimbursement rate but which are also billable to the Title XVIII Medicare Program must be billed to that program for facilities participating in the Title XVIII Medicare Program. Covered supplies, items and services include, but are not limited to, the following:

(A) Services, items and covered supplies required by federal or state law or regulation which must be provided by nursing facilities participating in the Title XIX Program;

(B) Semi-private room and board;

(C) Private room and board when it is necessary to isolate a recipient due to a medical or social condition examples of which may be contagious infection, loud irrational speech, etc.;

(D) Temporary leave of absence days for Medicaid recipients, not to exceed twelve (12) days for the first six (6) calendar months and not to exceed twelve (12) days for the second six (6) calendar months. Temporary leave of absence days must be specifically provided for in the recipient's plan of care and prescribed by a physician. Periods of time during which a recipient is away from the facility visiting a friend or relative are considered temporary leaves of absence;

(E) Provision of personal hygiene and routine care services furnished routinely and uniformly to all residents;

(F) All laundry services, including personal laundry;

(G) All dietary services, including special dietary supple-ments used for tube feeding or oral feeding. Dietary supplements prescribed by a physician are also covered items;

(H) All consultative services required by federal or state law or regulations;

(I) All therapy services required by federal or state law or regulations;

(J) All routine care items including, but not limited to, those items specified in Appendix A to this regulation;

(K) All nursing services and supplies including, but not limited to, those items specified in Appendix A to this regulation;

(L) All non-legend antacids, non-legend laxatives, non-legend stool softeners and non-legend vitamins. Providers may not elect which non-legend drugs in any of the four (4) categories to supply; any and all must be provided to residents as needed and are included in a facility's reimbursement rate; and

(M) Hospital leave days as defined in 13 CSR 70-10.070.

(6) Non-Covered Supplies, Items and Services. All supplies, items and services which are either not covered in a facility's reimbursement rate or are billable to another program in Medicaid, Medicare or other third party payor. Non-covered supplies, items and services include, but are not limited to, the following:

(A) Private room and board unless it is necessary to isolate a recipient due to a medical or social condition, examples of which may be contagious infection, loud irrational speech, etc. Unless a private room is necessary due to such a medical or social condition, a private room is a non-covered service and a Medicaid recipient or responsible party may therefore pay the difference between a facility's semi-private charge and its charge for a private room. Medicaid recipients may not be placed in private rooms and charged any additional amount above the facility's Medicaid reimbursement rate unless the recipient or responsible party specifically requests in writing a private room prior to placement in a private room and acknowledges that an additional amount not payable by Medicaid will be charged for a private room;

(B) Supplies, items and services for which payment is made under other Medicaid Programs directly to a provider or providers other than providers of the HIV nursing facility services; and

(C) Supplies, items and services provided non-routinely to residents for personal comfort or convenience.

(7) Allowable Cost Areas.

(A) Compensation of Owners.

1. Compensation of services of owners shall be an allowable cost area. Reasonableness of compensation shall be limited as prescribed in subsection (8)(Q).

2. Compensation shall mean the total benefit, within the limitations set forth in this regulation, received by the owner for the services rendered to the facility. This includes direct payments for managerial, administrative, professional and other services, amounts paid for the personal benefit of the owner, the cost of assets and

services which the owner receives from the provider, and additional amounts determined to be the reasonable value of the services rendered by sole proprietors or partners and not paid by any method previously described in this regulation. Compensation must be paid (whether in cash, negotiable instrument, or in kind) within seventy-five (75) days after the close of the period in accordance with the guidelines published in the Medicare Provider Reimbursement Manual, Part 1, Section 906.4.

(B) Covered services and supplies as defined in section (5) of this regulation.

(C) Capital Assets

1. Capital Assets shall include historical costs that would be capitalized under GAAP. For example, historical costs would include but not limited to, architectural fees, related legal fees, interest and taxes during construction.

2. For purposes of this regulation, any asset or improvement having a useful life greater than one (1) year in accordance with American Hospital Association depreciable guidelines, shall be capitalized.

3. In addition to the American Hospital Association depreciable guidelines, mattresses shall be considered a capitalized asset and shall have a three (3) year useful life.

(D) Depreciation - Vehicle.

1. An appropriate allowance for depreciation on vehicles which are a necessary part of the operation of a HIV nursing facility is an allowable cost. One vehicle per 60 licensed beds is allowable. For example, one vehicle is allowed for a facility with 0-60 licensed beds, two vehicles are allowed for a facility with 61-120 licensed beds, etc. Depreciation is treated as an administration cost and is reported on line 133 of the cost report, version MSIR-1 (3-95).

2. The depreciation must be identifiable and recorded in the provider's accounting records, based on the basis of the vehicle and prorated over the estimated useful life of the vehicle in accordance with American Hospital Association depreciable guidelines using the straight line method of depreciation from the date initially put into service.

3. The basis of vehicle cost at the time placed in service shall be the lower of:

A. the book value of the provider;

B. fair market value at the time of acquisition; or

C. the recognized IRS tax basis.

4. The basis of a donated vehicle will be allowed to the extent of recognition of income resulting from the donation of the vehicle. Should a dispute arise between a provider and the Division as to the fair market value at the time of acquisition of a depreciable vehicle, an appraisal by a third party is required. The appraisal cost will be the sole responsibility of the HIV nursing facility.

5. Historical cost will include the cost incurred to prepare the vehicle for use by the HIV nursing facility.

6. When a vehicle is acquired by trading in an existing vehicle, the cost basis of the new vehicle shall be the sum of undepreciated cost basis of the traded vehicle plus the cash paid.

(E) Insurance.

1. Property Insurance. Insurance cost on property of the HIV nursing facility used to provide HIV nursing facility services. Property insurance should be reported on line 107 of the cost report version MSIR-1 (3-95).

2. Other Insurance. Liability, umbrella, vehicle and other general insurance for the HIV nursing facility should be reported on line 136 of the cost report version MSIR-1 (3-95).

3. Workers' compensation insurance should be reported on the applicable payroll lines on the cost report for the employee salary groupings.

(F) Interest and Finance Costs.

1. Interest will be reimbursed for necessary loans for capital asset debt at the Chase Manhattan prime rate on July 3, 1995, plus two percentage (2%) points. For replacement beds, additional beds and new facilities placed in service after June 30, 1996, the prime rate will be updated annually on the first business day of each July based on the Chase Manhattan prime rate plus two percentage (2%) points.

2. Loans (including finance charges, prepaid costs and discounts) must be supported by evidence of a written agreement that funds were borrowed and repayment of the funds are required. The loan costs must be identifiable in the provider's accounting records, must be related to the reporting period in which the costs are claimed, and must be necessary for the operation, maintenance or acquisition of the provider's facility.

3. Necessary means that the loan be incurred to satisfy a financial need of the provider and for a purpose related to recipient care. Loans which result in excess funds or investments are not considered necessary.

4. A provider shall capitalize loan costs (i.e., lender's title and recording fees, appraisal fees, legal fees, escrow fees, and other closing costs), finance charges, prepaid interest and discounts. The loan costs shall be amortized over the life of the loan on a straight line basis.

5. If loans for capital asset debt exceed the facility asset value the interest associated with the portion of the loan or loans which exceeds the facility asset value shall not be allowable.

6. The following is an illustration of how allowable interest is calculated:

Outstanding Capital Asset Debt	$2,500,000
Term of Debt	25 years
Interest Rate (Chase Manhattan prime + 2%)	10%
Facility Asset Value	$2,000,000
Discount	$ 125,000
Loan Costs	$ 120,000

Allowable interest calculation - use the lessor of the facility asset value or the outstanding capital asset debt.

Other Allowable Borrowing Costs:

Discount - $2,000,000/ $2,500,000 x $125,000 =	$100,000
Loan Cost - $2,000,000/ $2,500,000 x $120,000=	$96,000
Allowable Interest - 2,000,000 X 10% =	$200,000
Discount - $100,000/ 25 years =	$ 4,000
Loan Cost - $96,000/ 25 years =	$ 3,840
Allowable Interest and Other Borrowing Costs	$207,840

7. Interest cost on vehicle debt for allowable vehicles per paragraph (7)(D)1. is treated as an administration cost and reported on line 134 of the cost report version MSIR-1 (3-95).

(G) Rental and Leases

1. Capitalized leases, as defined by GAAP, will be reimbursed in accordance with subsections (7)(C) and (7)(E).

2. Lease cost related to allowable vehicles per paragraph (7)(D)1. shall be treated as an administrative cost and be reported on line 135 of the cost report version MSIR-1 (3-95).

3. Operating leases, as defined by GAAP, will be part of the Fair Rental Value System.

(H) Real Estate and Personal Property Taxes. Taxes levied on or incurred by a facility used to provide HIV nursing facility services.

(I) Value of Services of Employees

1. Except as provided for in this regulation, the value of services performed by employees in the facility shall be included as an allowable cost area to the extent actually compensated, either to the employee or to the supplying organization.

2. Services rendered by volunteers such as those affiliated with the American Red Cross, hospital guilds, auxiliaries, private individuals and similar organizations shall not be an allowable cost, as the services have traditionally been rendered on a purely volunteer basis without expectation of any form of reimbursement by the organization through which the service is rendered or by the person rendering the service.

3. Services by priests, ministers, rabbis and similar type professionals shall be an allowable cost, provided that the services are not of a religious nature and are compensated. Costs of wardrobe and similar items shall not be allowable.

(J) Employee Benefits.

1. Retirement plans.

A. Contributions to Internal Revenue Service qualified retirement plans shall be an allowable cost.

B. Amounts funded to pension and qualified retirement plans, together with associated income, shall be recaptured, if not actually paid when due, as an offset to expenses on the cost report.

2. Deferred compensation plans.

A. Contributions shall be allowable costs when, and to the extent that, these costs are actually paid by the provider. Provider payments for unfunded deferred compensation plans will be considered an allowable cost only when paid to the participating employee.

B. Amounts paid by organizations to purchase tax-sheltered annuities for employees shall be treated as deferred compensation actually paid by the provider.

C. Amounts funded to deferred compensation plans together with associated income shall be recaptured, if not actually paid when due, as an offset to expenses on the cost report.

3. Types of insurance which are considered an allowable cost:

A. Credit life insurance (term insurance), if required as part of a mortgage loan agreement. An example, would be insurance on loans granted under certain federal programs.

B. Where the relative(s) or estate of the employee, excluding stockholders, partners and proprietors, is the beneficiary. This type of insurance is considered to be an employee benefit and is an allowable cost. This cost should be reported on the applicable payroll lines on the cost report for the employees salary groupings.

C. Health, disability, dental, etc., insurances for employees/owners shall be an allowable costs.

(K) Education and Training Expenses.

1. The cost of on-the-job training which directly benefits the quality of health care or administration at the facility shall be allowable, except for costs associated with Nurse Aide Training and Competency Evaluation Program.

2. Costs of education and training shall include travel costs but will not include leaves of absence or sabbaticals.

(L) Organizational Costs

1. Organizational cost items include the following: legal fees incurred in establishing the corporation or other organizations; necessary accounting fees; expenses of temporary directors and organizational meetings of directors and stock-holders; and fees paid to states for incorporation.

2. Organizational costs shall be amortized ratably over a period of sixty (60) months beginning with the date of organization. When the provider enters the program more than sixty (60) months after the date of organization, no organizational costs shall be recognized.

3. Where a provider is organized within a five (5) year period prior to its entry into the program and has properly capitalized organizational costs using a sixty (60) month amortization period, no change in the rate of amortization is required. In this instance the unamortized portion of organizational costs is an allowable cost under the program and shall be amortized over the remaining part of the sixty (60) month period.

4. For change in ownership after July 18, 1984, allowable amortization will be limited to the prior owner's allowable unamortized portion of organizational cost.

(M) Advertising Costs. Advertising costs which are reasonable and appropriate are allowable. The costs must be a common and accepted occurrence for providing HIV nursing facility services.

(N) Cost of Supplies and Services Involving Related Parties. Costs of goods and services furnished by related parties shall not exceed the lower of the cost to the supplier or the prices of comparable goods or services obtained elsewhere. In the cost report a provider shall identify related party suppliers and the type, the quantity and costs to the related party for goods and services obtained from each such supplier.

(O) Minimum Utilization. In the event the occupancy rate of a facility is below eighty-five percent (85%), the administration and capital cost components will be adjusted as though the provider experienced eighty-five percent (85%) occupancy. In no case may costs disallowed under this provision be carried forward to succeeding periods.

(P) Central Office/Home Office or Management Company Costs. The allowability of the individual cost items contained within central office/home office or management company costs will be determined in accordance with all other provisions of this regulation. The total of central office/home office and/or management company costs, as reported on lines 121 and 122 of the cost report, version MSIR-1 (3-95), are limited to seven percent (7%) of gross revenues less contractual allowances.

(Q) Start-Up Costs. Expenses incurred prior to opening, as defined in HIM-15 as start-up costs, shall be amortized on a straight line method over sixty (60) months. The amortization shall be reported on the same line on the cost report as the original start-up costs are reported. For example, RN salary prior to opening would be amortized over sixty (60) months and would be reported on line 51 of the cost report, version MSIR-1 (3-95), RN.

(R) Reusable Items. Costs incurred for items, such as linen and bedding, but not limited to, shall be classified as inventory when purchased and expensed as the item is used.

(S) Nursing Facility Reimbursement Allowance (NFRA). Effective for service dates on or after October 1, 1996, the fee assessed to HIV nursing facilities in the State of Missouri for the privilege of doing business in the state will be an allowable cost.

(8) Non-Allowable Costs. Costs not reasonably related to HIV nursing facility services shall not be included in a provider's costs. Non-allowable costs include, but are not limited to, the following:

(A) Amortization on intangible assets, such as goodwill, leasehold rights, covenants and purchased certificates of need;

(B) Bad debts, contractual allowances, courtesy discounts, charity allowances, and similar adjustments or allowances are offsets to revenues and, therefore, not included in allowable costs;

(C) Capital cost increases due solely to changes in ownership;

(D) Charitable contributions;

(E) Compensation paid to a relative or an owner through a related party to the extent it exceeds the limitations established under subsection (7)(A) of this regulation;

(F) Costs such as legal fees, accounting and administrative costs, travel costs, and the costs of feasibility studies, which are attributable to the negotiation or settlement of the sale or purchase of any capital asset by acquisition or merger for which any payment has been previously made under the program;

(G) Directors' fees included on the cost report in excess of two-hundred dollars ($200) per month, per individual;

(H) Federal, state or local income and excess profit taxes, including any interest and penalties paid thereon;

(I) Late charges and penalties;

(J) Finder's fees;

(K) Fund-raising expenses;

(L) Interest expense on loans for intangible assets;

(M) Legal fees related to litigation involving the Department and attorneys fees which are not related to the provision of HIV nursing facility services, such as litigation related to disputes between or among owners, operators or administrators;

(N) Life insurance premiums for officers and owners and related parties except the amount relating to a bona fide nondiscriminatory employee benefits plan;

(O) Non-covered supplies, services and items as defined in section (6);

(P) Owner's Compensation in excess of the applicable range of the most recent survey of administrative salaries paid to individuals other than owners for proprietary and non-proprietary providers as published in the updated Medicare Provider Reimbursement Manual Part 1, Section 905.2 and based upon the total number of working hours.

1. The applicable range will be determined as follows:

   A. Number of licensed beds owned or managed.

   B. Owner/administrators will be adjusted on the basis of the high range. Owners included in home office costs or management company costs will be adjusted on the high range. All others will be calculated on the median range;

2. The salary identified above will be apportioned on the basis of hours worked in the facility/ies, home office or management company as applicable to total hours in the facility/ies, home office or management company.

(Q) Prescription drugs;

(R) Religious items or supplies or services of a primarily religious nature performed by priests, rabbis, ministers or other similar types of professionals;

(S) Research costs;

(T) Resident personal purchases provided non-routinely to residents for personal comfort or convenience;

(U) Salaries, wages or fees paid to nonworking officers, employees or consultants;

(V) Cost of stockholder meetings or stock proxy expenses;

(W) Taxes or assessments for which exemptions are available;

(X) Value of services (imputed or actual) rendered by nonpaid workers or volunteers;

(Y) All costs associated with Nurse Aide Training and Competency Evaluation Program; and

(Z) Losses from disposal of assets.

(9) Revenue Offsets

(A) Other revenues must be identified separately in the cost report. These revenues are offset against expenses. Such revenues include, but are not limited to, the following:

1. Income from telephone services;

2. Sale of employee and guest meals;

3. Sale of medical abstracts;

4. Sale of scrap and waste food or materials;

5. Cash, trade, quantity, time and other discounts;

6. Purchase rebates and refunds;

7. Recovery on insured loss;

8. Parking lot revenues;

9. Vending machine commissions or profits;

10. Sales from supplies to individuals other than HIV nursing facility recipients;

11. Room reservation charges other than covered therapeutic home leave days and hospital leave days;

12. Barber and beauty shop revenue;

13. Private room differential;